FAMILY PSYCHIATRIC ASSOCIATES

Dennis T. Cozzens, M.D.
Thomas J. Kunzig, L.C.S.W.
Kimberly J. Carr, L.C.S.W.
Amelia Bindas, PhD
Harold Erik Ramsey, Family PMHNP-BC

Date: _____ Location: Alexandria _____ Woodbridge_____

Patient Name: Last First MI	Date of Birth:	Age:	Sex: Male Female
Social Security No:	Email:_____M_____S_____D_____W_____		
Home Address: Street Apt. # City State Zip			Home Phone: Cell Phone:
Occupation	Employed by: Address:		Work Phone:
Insurance Subscriber:	Name (if different from patient) DOB: SSN:		Home Phone: Work Phone:
Home Address: Street Apt. # City State Zip			
Employed By:	Address:		
Primary Insurance: Company Name Address	ID #		Group #
Referred by:_____ If you have an allergy to any medication, please list:			
Person to notify in case of emergency:	Relationship:	Home Phone:	Work Phone:

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I, the undersigned, do certify that I (or my dependents) have insurance coverage with the above named insurance, and assign directly to Dennis T. Cozzens, M.D., Kimberly J. Carr, L.C.S.W., Thomas J. Kunzig, L.C.S.W., Maura McGovern-Moore, L.C.S.W., Mary McDonald, L.C.S.W., Harol Erik Ramsey, Family PMHNP-BC, insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance.
I am ___am not__covered by Medicare or Medicaid. I understand that if any account becomes delinquent, the doctor, his assignees, or lawful agents may pursue collections procedures. I will be responsible for all collection costs, interests, and attorney fees. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorized the use of this signature on all insurance submissions.

_____ _____

Signature Date